Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $1,160.20 for date of service 11/15/01.

   b. The request was received on 03/18/02

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA(s)
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/23/02
   b. HCFA(s)
   c. TWCC 62 form
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/25/02. The response from the insurance carrier was received in the Division on 05/01/02. Based on the submitted information the insurance carrier's response is timely.

III. PARTIES' POSITIONS

1. Requestor:

   The Requestor did not submit a letter requesting dispute resolution in their packet.

2. Respondent:

"Texas Fee Guidelines provide for reimbursement of Sterile Trays and Anesthesia supplies at "the **lesser** of the doctor's usual charge or fair and reasonable reimbursement." Reimbursement has been made according to fee guidelines at what our research has determined to be fair and reasonable rate for these supplies when billed without documentation to justify charges in excess of that amount. The documentation submitted includes only a breakdown of the extravagant amounts charged for each item and not of the actual cost to the provider which would serve as the basis for properly determining if additional reimbursement is due. Included is an additional $130 described as an IV Start Fee which is not a supply charge at all. Manufacturer's invoices were requested but have never been submitted."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/15/01.

2. The denial code listed on the EOB is "M-REDUCED TO FAIR AND REASONABLE."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
11/15/01	99070-ST	$969.80	$150.00	M	DOP	MFG SGR; (V)(B)(1-2), General Instructions (GI)(III)(A); TWCC Rule Sec. 413.011 (d)	The issue is what is "fair and reasonable" reimbursement for the services rendered. The referenced GI states, "…(DOP) in the …(MAR) column indicates that the value of this service shall be determined by written documentation…" The burden is on the Requestor to show that the amount of reimbursement requested is "fair and reasonable." The provider has only submitted an itemized list of charges that make up the total billed amount. The provider has not submitted documentation that demonstrates that the amount of reimbursement requested is "fair and reasonable" or that meets the criteria of Sec. 413.011 (d) of the Texas Labor Code. Therefore, no additional reimbursement is recommended.
11/15/01	99070-AS	$490.40	$150.00	M	DOP	MFG SGR; (V)(B)(1-2), General Instructions (GI)(III)(A); TWCC Rule Sec. 413.011 (d)	The issue is what is "fair and reasonable" reimbursement for the services rendered. The referenced GI states, "…(DOP) in the …(MAR) column indicates that the value of this service shall be determined by written documentation…" The burden is on the Requestor to show that the amount of reimbursement requested is "fair and reasonable." The provider has only submitted an itemized list of charges that make up the total billed amount. The provider has not submitted documentation that demonstrates that the amount of reimbursement requested is "fair and reasonable" or that meets the criteria of Sec. 413.011 (d) of the Texas Labor Code. Therefore, no additional reimbursement is recommended.
Totals		$1,460.20	$300.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision is hereby issued this 10th day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.